ASSEMBLY BILL No. 1111

Introduced by Assembly Member Frommer

February 22, 2005

An act to add Article 3.12 (commencing with Section 1357.40) to Chapter 2.2 of Division 2 of the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1111, as introduced, Frommer. Individual health coverage market reform.

Existing law provides for the licensing and regulation of health care service plans by the Department of Managed Health Care. A willful violation of these provisions by a health care service plan is a crime.

This bill would enact various market reforms relative to individual health care coverage. The bill would impose requirements on age categories and geographic region service areas used by plans. The bill would require plans to fairly and affirmatively market and sell all plan contracts available in each service area. The bill would impose limitations on late enrollee and preexisting condition exclusions. The bill would require contracts offered to individuals under these provisions to be renewable except under particular circumstances. The bill would impose limitations on plan contract premiums. The bill would impose certain requirements on solicitors selling plan contracts and relative to the marketing materials used for individual plan contracts. The bill would authorize the Director of Managed Health Care to adopt regulations to implement these provisions. The bill would enact other related provisions.

Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Article 3.12 (commencing with Section 1357.40) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 3.12. Individual Health Coverage Market Reform

1357.40. As used in this article, the following terms have the following meanings:

(a) "Dependent" means the spouse or child of an eligible individual, subject to applicable terms of the health care plan contract covering the individual.

(b) "Eligible individual" means a person who purchases an individual health care service plan contract who has met any statutorily authorized applicable waiting period requirements.

(c) "In force business" means an existing health benefit plan contract issued by the plan to an individual.

(d) "Late enrollee" means an eligible individual or dependent who has declined enrollment in a health benefit plan at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan. However, an eligible individual or dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) He or she was covered under another individual or employer health benefit plan or no share-of-cost Medi-Cal coverage at the time the individual was eligible to enroll.

(B) He or she certified at the time of the initial enrollment that coverage under another individual or employer health benefit plan or no share-of-cost Medi-Cal coverage was the reason for declining enrollment, provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) He or she has lost or will lose coverage under an employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an individual or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, divorce, or loss of no share-of-cost Medi-Cal coverage.

(D) He or she requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under an employer health benefit plan.

(2) A court has ordered that coverage be provided for a spouse or minor child under a covered individual's health benefit plan.

(3) The individual is a dependent of an enrolled eligible individual who has lost or will lose his or her no share-of-cost Medi-Cal coverage and requests enrollment within 30 days after notification of this loss of coverage.

(e) "New business" means a health care service plan contract issued to an individual that is not the plan's in force business.

(f) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the individual's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(g) "Creditable coverage" means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The Medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) 10 U.S.C. Sec. 1071 and following).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under (Federal Individuals Health Benefits Program (FEHBP) 10 U.S.C. Sec. 8901 and following).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(h) "Rating period" means the period for which premium rates established by a plan are in effect and shall be no less than six months.

(i) "Risk adjusted individual risk rate" means the rate determined for an eligible individual in a particular risk category after applying the risk adjustment factor.

(j) "Risk adjustment factor" means the percentage adjustment to be applied equally to each standard individual risk rate based upon any expected deviations from standard cost of services. This factor may not be more than 115 percent or less than 85 percent.

(k) "Risk category" means the following characteristics of an eligible individual: age, geographic region, and family composition of the individual, plus the health benefit plan selected by the individual.

(1) No more than the following age categories may be used in determining premium rates:

Under 30
30-39
40-49
50-54
55-59
60-64
65 and over.

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided by the federal Medicare program pursuant to Title XVIII of the Social Security Act.

(2) Health care service plans shall base rates to individuals using no more than the following family size categories:

(A) Single.
(B) Married couple.
(C) One adult and child or children.
(D) Married couple and child or children.

(3) (A) In determining rates for individuals, a plan that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and divide no county into more than two regions. Plans shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state's population. Geographic regions established pursuant to this section shall, as a group,

cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

(B) (i) In determining rates for individuals, a plan that does not operate statewide shall use no more than the number of geographic regions in the state that is determined by the following formula: the population, as determined in the last federal census, of all counties that are included in their entirety in a plan's service area divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. No region may be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. No plan shall have less than one geographic area.

(ii) If the formula in clause (i) results in a plan that operates in more than one county having only one geographic region, then the formula in clause (i) shall not apply and the plan may have two geographic regions, provided that no county is divided into more than one region. Nothing in this section shall be construed to require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan's existing service area.

(l) "Standard individual risk rate" means the rate applicable to an eligible individual in a particular risk category.

1357.401. Every health care service plan offering plan contracts to individuals shall, in addition to complying with the provisions of this chapter and the rules adopted thereunder, comply with the provisions of this article.

1357.402. This article shall not apply to health plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, Medi-Cal contracts with the State Department of Health Services, long-term care coverage, or specialized health plan contracts.

1357.4025. Nothing in this article shall be construed to preclude the application of this chapter to either of the following:

(a) An association, trust, or other organization acting as a "health care service plan," as defined under Section 1345.

(b) An association, trust, or other organization or person presenting information regarding a health care service plan to persons who may be interested in subscribing or enrolling in the plan.

1357.403. (a) Upon the effective date of this article, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are sold to individuals in each service area in which the plan provides or arranges for the provision of health care services. Each plan shall make available to each individual all individual health care service plan contracts which the plan offers and sells to individuals in this state.

(b) The plan may not reject an application from an individual for a health care service plan contract if the individual agrees to make the required premium payments and the individuals and their dependents who are to be covered by the plan contract work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.

(c) No plan or solicitor shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct individuals to refrain from filing an application for coverage with a plan because of the health status, claims experience, industry, occupation of the individual, or geographic location provided that it is within the plan's approved service area.

(2) Encourage or direct individuals to seek coverage from another plan because of the health status, claims experience, industry, occupation of the individual, or geographic location provided that it is within the plan's approved service area.

(d) No plan shall, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the individual. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of

the health status, claims experience, industry, occupation, or geographic area of the individual.

(e) No policy or contract that covers an individual may establish rules for eligibility, including continued eligibility, of any individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors: (1) health status, (2) medical condition, including physical and mental illnesses, (3) claims experience, (4) receipt of health care, (5) medical history, (6) genetic information, (7) evidence of insurability, including conditions arising out of acts of domestic violence, or (8) disability.

(f) Each plan shall comply with the requirements of Section 1374.3.

1357.405. Except in the case of a late enrollee, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible individual, a plan may not exclude any eligible individual or dependent who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that individual or dependent. No plan contract may limit or exclude coverage for a specific eligible individual or dependent by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted by Section 1357.406.

1357.406. (a) Preexisting condition provisions of a plan contract shall not exclude coverage for a period beyond six months following the individual's effective date of coverage and may only relate to conditions for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) A plan that does not utilize a preexisting condition provision may impose a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period no premiums shall be charged to the enrollee or the subscriber.

(c) In determining whether a preexisting condition provision or a waiting or affiliation period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage

under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. A plan shall also credit any time an eligible individual must wait before enrolling in the plan, including any affiliation or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

(d) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(e)).

(e) A health care service plan may not impose a preexisting condition exclusion to any of the following:

(1) To a newborn individual, who, as of the last day of the 30-day period beginning with the date of birth, has applied for coverage through the plan.

(2) To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning with the date of adoption or placement for adoption, is covered under creditable coverage and applies for coverage through the plan. This provision shall not apply if, for 63 continuous days, the child is not covered under any creditable coverage.

(3) To a condition relating to benefits for pregnancy or maternity care.

1357.407. No plan contract may exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No premium shall be charged to the late enrollee until the exclusion period has ended.

1357.408. All health care service plan contracts offered to an individual shall provide to subscribers and enrollees at least all of

the basic health care services included in subdivision (b) of Section 1345, and in Section 1300.67 of the California Code of Regulations.

1357.409. No plan shall be required to offer a health care service plan contract or accept applications for such a contract pursuant to this article in the case of any of the following:

(a) To an individual, where the individual is not physically located in a plan's approved service areas, or where an eligible individual and dependents who are to be covered by the plan contract do not work or reside within a plan's approved service areas.

(b) To an individual, if the individual does not apply for coverage within 30 days following the individual's annual birth date. If a plan intends to limit enrollment of new individuals pursuant to this subdivision, which shall be known as the "birthday rule," the plan shall publicize its use of the rule on all marketing documents.

(c) Within a specific service area or portion of a service area where a plan reasonably anticipates and demonstrates to the satisfaction of the director that it will not have sufficient health care delivery resources to assure that health care services will be available and accessible to the eligible individual and dependents of the individual because of its obligations to existing enrollees. Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity have become impaired.

(d) Offer coverage to an individual or an eligible individual as defined under paragraph (2) of subdivision (b) of Section 1357.40 which, within 12 months of application for coverage, disenrolled from a plan contract offered by the plan.

(e) A health care service plan that, as of December 31 of the prior year, had a total enrollment of fewer than 100,000 and 50 percent or more of the plan's total enrollment have premiums paid by the Medi-Cal program.

(f) A social health maintenance organization, as described in subdivision (a) of Section 2355 of the federal Deficit Reduction Act of 1984 (Public Law 97-369), that, as of December 31 of the prior year, had a total enrollment of fewer than 100,000 and has

50 percent or more of the organization's total enrollment premiums paid by the Medi-Cal program or Medicare programs, or by a combination of Medi-Cal and Medicare. In no event shall this exemption be based upon enrollment in Medicare supplement contracts, as described in Article 3.5 (commencing with Section 1358).

1357.410. The director may require a plan to discontinue the offering of contracts or acceptance of applications from any individual upon a determination by the director that the plan does not have sufficient financial viability, or organizational and administrative capacity to assure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

1357.411. All health care service plan contracts offered to an individual shall be renewable with respect to all eligible individuals or dependents at the option of the individual contractholder except:

(a) For nonpayment of the required premiums.

(b) For fraud or misrepresentation by the individual or his or her representatives.

(c) When the plan ceases to provide or arrange for the provision of health care services for new individual health care service plan contracts in this state; provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefits plans in this state is provided to the director and to the contractholder at least 180 days prior to the discontinuation of the coverage.

(2) Individual health care service plan contracts subject to this chapter shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan which remains in force, any plan that ceases to offer for sale new individual health care service plan contracts shall continue to be governed by this article with respect to business conducted under this article.

(3) Except as authorized under subdivision (d) of Section 1357.409 and Section 1357.410, a plan that ceases to write new

individual business in this state after the effective date of this article shall be prohibited from offering for sale new individual health care service plan contracts in this state for a period of five years from the date of notice to the director.

(d) When the plan withdraws a health care service plan contract from the individual market; provided, the plan notifies all affected contractholders and the director at least 90 days prior to the discontinuation of those contracts, and the plan makes available to the individual all plan contracts that it makes available to new individual business; and provided, that the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1357.412.

1357.412. Premiums for contracts offered or delivered by plans on or after the effective date of this article shall be subject to the following requirements:

(a) (1) The premium for new business shall be determined for an eligible individual in a particular risk category after applying a risk adjustment factor to the plan's standard individual risk rates. The risk adjusted individual risk rate may not be more than 115 percent or less than 85 percent of the plan's applicable standard individual risk rate.

(2) The premium charged an individual for new business shall be equal to the risk adjusted individual risk rate.

(3) The standard individual risk rates applied to an individual for new business shall be in effect for no less than six months.

(b) (1) The premium for in force business shall be determined for an eligible individual in a particular risk category after applying a risk adjustment factor to the plan's standard individual risk rates. The risk adjusted individual risk rates may not be more than 115 percent or less than 85 percent of the plan's applicable standard individual risk rate. The risk adjustment factor applied to an individual may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period. The risk adjustment factor for an individual may not be modified more frequently than every 12 months.

(2) The premium charged an individual for in force business shall be equal to the risk adjusted individual risk rate. The standard individual risk rates shall be in effect for no less than six months.

(3) For a contract that a plan has discontinued offering, the risk adjustment factor applied to the standard individual risk rates for the first rating period of the new contract that the individual elects to purchase shall be no greater than the risk adjustment factor applied in the prior rating period to the discontinued contract. However, the risk adjusted individual risk rate may not be more than 115 percent or less than 85 percent of the plan's applicable standard individual risk rate. The risk adjustment factor for an individual shall not be modified more frequently than every 12 months.

1357.413. Plans shall apply standard individual risk rates consistently with respect to all individuals

1357.414. In connection with the offering for sale of any plan contract to an individual, each plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

(a) The extent to which premium rates for a specified individual are established or adjusted in part based upon the actual or expected variation in service costs or actual or expected variation in health condition of the individuals and dependents.

(b) The provisions concerning the plan's right to change premium rates and the factors other than provision of services experience that affect changes in premium rates.

(c) Provisions relating to the guaranteed issue and renewal of contracts.

(d) Provisions relating to the effect of any preexisting condition provision.

(e) Provisions relating to the individual's right to apply for any contract written, issued, or administered by the plan at the time of application for a new health care service plan contract, or at the time of renewal of a health care service plan contract.

(f) The availability, upon request, of a listing of all the plan's contracts and benefit plan designs offered to individuals, including the rates for each contract.

(g) At the time it offers a contract to an individual, each plan shall provide the small employer with a statement of all of its plan contracts offered to individuals, including the rates for each plan contract, in the service area in which the individuals and eligible dependents who are to be covered by the plan contract work or reside. For purposes of this subdivision, plans that are

affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.

(h) Each plan shall do all of the following:

(1) Prepare a brochure that summarizes all of its plan contracts offered to individuals and to make this summary available to any individual and to solicitors upon request. The summary shall include for each contract information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard individual risk rates, an explanation of the manner in which creditable coverage is calculated if a preexisting condition or affiliation period is imposed, and a telephone number that can be called for more detailed benefit information. Plans are required to keep the information contained in the brochure accurate and up to date and, upon updating the brochure, send copies to solicitors and solicitor firms with whom the plan contracts to solicit enrollments or subscriptions.

(2) For each contract, prepare a more detailed evidence of coverage and make it available to individuals, solicitors, and solicitor firms upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making contract selections.

(3) Provide to individuals and solicitors, upon request, for any given individual, the standard individual risk rate. When requesting this information, individuals, solicitors, and solicitor firms shall provide the plan with the information the plan needs to determine the individual's risk adjusted individual risk rate.

(4) Provide copies of the current summary brochure to all solicitors and solicitor firms contracting with the plan to solicit enrollments or subscriptions from individuals. For purposes of this subdivision, plans that are affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.

(i) Every solicitor or solicitor firm contracting with one or more plans to solicit enrollments or subscriptions from small employers shall do all of the following:

(1) When providing information on contracts to an individual but making no specific recommendations on particular plan contracts:

(A) Advise the individual of the plan's obligation to sell to any individual any plan contract it offers to individuals and provide them, upon request, with the actual rates that would be charged to that individual for a given contract.

(B) Notify the individual that the solicitor or solicitor firm will procure rate and benefit information for the individual on any plan contract offered by a plan whose contract the solicitor sells.

(C) Notify the individual that upon request the solicitor or solicitor firm will provide the individual with the summary brochure required under paragraph (1) of subdivision (h) for any plan contract offered by a plan with whom the solicitor or solicitor firm has contracted with to solicit enrollments or subscriptions.

(2) When recommending a particular benefit plan design or designs, advise the individual that, upon request, the agent will provide the individual with the brochure required by paragraph (1) of subdivision (h) containing the benefit plan design or designs being recommended by the agent or broker.

(3) Prior to filing an application for an individual for a particular contract:

(A) For each of the plan contracts offered by the plan whose contract the solicitor or solicitor firm is offering, provide the individual with the benefit summary required in paragraph (1) of subdivision (h) and the standard individual risk rate for that individual.

(B) Notify the individual that, upon request, the solicitor or solicitor firm will provide the individual with an evidence of coverage brochure for each contract the plan offers.

(C) Notify the individual that actual rates may be 15 percent higher or lower than the standard rates, depending on how the plan assesses the risk of the individual.

(D) Notify the individual that, upon request, the solicitor or solicitor firm will submit information to the plan to ascertain the individual's risk adjusted individual risk rate for any contract the plan offers.

(E) Obtain a signed statement from the individual acknowledging that the individual has received the disclosures required by this section.

1357.415. (a) At least 20 business days prior to renewing or amending a plan contract subject to this article which will be in

force on the operative date of this article, a plan shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (j) of Section 1357 and Section 1357.412. The certified statement shall set forth the standard individual risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be renewed or amended. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

(b) At least 20 business days prior to offering a plan contract subject to this article, all plans shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (j) of Section 1357.40 and Section 1357.412. The certified statement shall set forth the standard individual risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be offered. Plans that will be offering to an individual plan contracts approved by the director prior to the effective date of this article shall file a notice of material modification in accordance with this subdivision. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

(c) Prior to making any changes in the risk categories, risk adjustment factors or standard individual risk rates filed with the director pursuant to subdivision (a) or (b), the plan shall file as an amendment a statement setting forth the changes and certifying that the plan is in compliance with subdivision (j) of Section 1357.40 and Section 1357.412. A plan may commence offering plan contracts utilizing the changed risk categories set forth in the certified statement on the 31st day from the date of the filing, or at an earlier time determined by the director, unless the director disapproves the amendment by written notice, stating the

reasons therefor. If only the standard individual risk rate is being changed, and not the risk categories or risk adjustment factors, a plan may commence offering plan contracts utilizing the changed standard individual risk rate upon filing the certified statement unless the director disapproves the amendment by written notice.

(d) Periodic changes to the standard individual risk rate that a plan proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subdivision (a), (b), or (c).

(e) Each plan shall maintain at its principal place of business all of the information required to be filed with the director pursuant to this section.

(f) Each plan shall make available to the director, on request, the risk adjustment factor used in determining the rate for any particular small employer.

(g) Nothing in this section shall be construed to limit the director's authority to enforce the rating practices set forth in this article.

1357.417. The director may issue regulations that are necessary to carry out the purposes of this article. Prior to the public comment period required on the regulations under the Administrative Procedure Act, the director shall provide the Insurance Commissioner with a copy of the proposed regulations. The Insurance Commissioner shall have 30 days to notify the director in writing of any comments on the regulations. The Insurance Commissioner's comments shall be included in the public notice issued on the regulations. Any rules and regulations adopted pursuant to this article may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Until December 31, 2006, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety or general welfare.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section

17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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